South Carolina Workers' Compensation Commission
1612 Marion Street ● Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ SSN: ___ - ___ - _____ Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) - _____ Work Phone: ( ) - _____ Insurance Carrier: _____

Preparer's Name: _____ Law Firm: _____ Preparer's Phone #: ( ) - _____

Complete each information blank. To request a hearing, check Box 12b., indicate the kinds of benefits claimed by checking the box(es) at Lines 6, 7 and 8 and file this form in duplicate.

A claim for workers' compensation benefits is made based on the following grounds:

The claimant is _____ (relationship to employee) of _____ (employee's name)

1. The employee sustained an accidental injury to the _____ (Part of Body Hurt) on _____ (Month Day Year) in _____ County, State of _____.
2. Both the employee and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
3. The relationship of employer and employee existed at the time of injury.
4. At the time of the injury the employee was performing services arising out of and in the course of employment.
5. Notice of the accidental injury was given to the employer on _____ (Month Day Year) in the following manner:

_____

☐ 6. Due to injury, the employee received medical examination and treatment which remains unpaid by the employer.

☐ 7. Due to injury, the employee lost compensable time from work and wages for the periods of:

_____

☐ 8. The employee died on _____ (Month Day Year) as a result of the accidental injury, and death compensation is claimed.

9. At the time of the injury, the employee was paid weekly wages of $_____. The claimant demands an accounting of days worked and wages earned as provided by law.
10. Further grounds of claim:

_____

11. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.

☐ 12a. **I am filing a claim. I am not requesting a hearing at this time.**

☐ 12b. **I am requesting a hearing. A $25 filing fee is required.**

_____ _____
Signature of Claimant/Representative Date

Refer to R.67-205, R.67-206, R.67-207, and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Judicial Department.